Research Letters

Mandatory HIV Testing of Infants and Rates of Follow-Up Care

In response to landmark findings demonstrating reduced vertical transmission of HIV with the administration of zidovudine in the prepartum, antepartum, and postpartum periods,[1] New York State passed legislation in 1996 that would reveal the results of previously anonymous HIV serosurveys of newborns that had been used to track rates of HIV infection among childbearing women and infants. That policy met with opposition from many individuals who argued that mandatory detection of passively acquired maternal antibodies in the infant was tantamount to mandatory testing of pregnant women.[2] Given that mandatory testing abrogates a mother's choice, it is possible that women who do not wish to learn their serostatus might be deterred from seeking infant care in settings where HIV test results are given.

To assess the validity of this concern, we conducted a systematic sampling of 786 women whose names were obtained from the hospital delivery logs of the postpartum wards at 3 hospitals in Brooklyn, NY. All participants completed a face-to-face interview assessing prenatal care, HIV testing history, and sociodemographic and behavioral risk factors. Approximately 3 months after the baby's birth, the clinic records of each mother were reviewed to determine whether the initial scheduled newborn visit had been kept. Interviews occurred before (July 1996–December 1996; n=390) and after (August 1997–January 1998; n=396) implementation of the legislation. The pre- and postlegislation groups differed somewhat in terms of race/ethnicity and history of HIV testing before the index pregnancy (Table 1).

TABLE 1—Demographic Characteristics of Women in Surveys Taken Before and After Mandatory Newborn HIV Testing: Brooklyn, NY, 1996–1998

	Prelegislation (n=390)	Postlegislation (n=396)
Age, y[a]	26.6 (6.4)	26.1 (6.4)
Monthly income, US$[a]	597.2 (1083.2)	602.3 (551.7)
Race/ethnicity, %*		
Black	74.4	83.6
Latina	19.2	11.9
Other	6.4	4.5
Born in United States, %	41.5	46.0
Drug use,[b] %	4.6	2.5
Tested for HIV before index pregnancy, %*	53.4	64.3
Received any prenatal care, %	97.7	96.2

[a]Data presented are means; numbers in parentheses are standard deviations.
[b]Crack, injectable drugs.
*$P<.05$.

Overall, 78.5% of the women had engaged in voluntary HIV testing during their pregnancy. Women were more likely to report voluntary HIV testing in the period after mandatory newborn testing (73.9% vs 82.7%; $P<.05$). After age, race/ethnicity, lifetime prevalence of HIV testing before pregnancy, prenatal care, and whether the participants were foreign born were adjusted for, women were more likely to have engaged in voluntary HIV testing after implementation of the legislation (odds ratio =1.8; 95% confidence interval=1.3, 2.7). Clinic records confirmed that 84.2% of the women brought their infant in for the initial scheduled newborn visit. There were no statistically significant differences between rates of return before vs after mandatory HIV testing (82.6% vs 85.8%; $P=.24$). Of the 159 women who did not engage in voluntary testing, 75.8% presented for their newborn appointment; among these, there were again no significant differences across time periods (77.4% vs 73.4%, $P=.57$) after the above covariates were adjusted for ($\chi^2=9.7$, $P=.21$).

Our study found higher voluntary prenatal testing rates but no change in rates of return for initial newborn care after implementation of mandatory newborn HIV testing. While the ethics of mandatory testing in the postpartum period remains an appropriate subject for discussion by legislators considering following New York's lead, we found no evidence that fears of negative effects on health care–seeking behaviors should be central to that discourse. □

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